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Restorative and wellbeing care in Australian residential aged care facilities

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Key Messages

The delivery of restorative and wellbeing care is important for improving independence and self-assurance in older Australians. However, in Australia the routine delivery of restorative and wellbeing care in residential aged care (RAC) is limited. The minimum care standards, workforce structure, funding, and data collection for allied health services in RAC are significant barriers to providing restorative and wellbeing care in Australia.

RAC facilities are required to provide access to allied health services under The Aged Care Quality Standards. However, this does not guarantee residents receive allied health services and the restorative and wellbeing care they provide.

The ability of allied health services to support all aged care staff to proactively deliver restorative and wellbeing care in RAC is hampered by the high turnover and third-party contract employed nature of the workforce.

Residents and providers are unable to claim subsidies for key allied health services that improve physical and mental capacity and social participation in RAC under the Medicare Benefits Schedule (MBS) or Australian National Aged Care Classification (AN-ACC). This creates additional barriers to accessing affordable restorative and wellbeing care.

Australia does not meet international quantity standards for providing restorative and wellbeing care in RAC, resulting in higher rates of falls and poorer function and quality of life. The conflicting definitions of allied health within Australia complicate international comparison and recommendations for allied health service delivery benchmarks in RAC.

Data on allied health service delivery in RAC is not published at a facility level limiting consumer choice when selecting a RAC facility to suit their restorative and wellbeing needs, market workforces, and quality and safety benchmarking. This should be addressed by modifying the existing Quality Indicator Program to include the quantity of allied health services delivered in each facility as recommended by the Royal Commission into Aged Care Quality and Safety.

Recommendations

1

Simplify

- Amend the Quality-of-care Principles to minimise service disruption and support equitable access to allied health services.
- Collapse existing allied health funding in RAC under the AN-ACC.

2

Resource evidenced-based quantities and types of care

- All Australian RAC facilities should provide a high-intensity short-term restorative care program for RAC residents' post-acute care.
- Increase RAC resourcing of restorative and wellbeing care to match other Australian populations and evidence-based literature.
- Resource, trial, and evaluate partnerships between allied health and RAC providers.

3

Consumer-centred data

- Collect and report data on all allied health services in RAC.
- Conduct a consumer-centred evaluation of the allied health Quality Indicators.
- Utilise allied health and RAC resident outcome data to inform outcome-centred allied health service delivery in RAC in the future.

Executive Summary

Australian residential aged care (RAC) residents require restorative and wellbeing care to manage health conditions and maintain function and quality of life. Restorative and wellbeing care in RAC is the responsibility of all care staff. However, it is championed by allied health services, which are health services outside of nursing and medicine professions. In Australia, the quantity and breadth of allied health service delivery in RAC falls below evidence-based and interventional benchmarks causing RAC residents to receive less opportunity to achieve the functional and quality of life benefits associated with restorative and wellbeing care provision.

This Policy Brief discusses the allied health governance, data collection, and funding barriers to accessing or providing high-quality restorative and wellbeing care in Australian RAC. The most significant of these barriers is that provision of restorative and wellbeing services in RAC facilities is not guaranteed by minimum standards outlined in the Quality-of-Care Principles.

In addition, allied health funding in Australian RAC is highly fragmented, unclear, and resources a limited quantity and type of allied health services.

Allied health care professionals also have limited opportunity to centre the broader RAC care team around restorative and wellbeing care delivery as they inconsistently interact with RAC care staff due to casual and contract employment conditions.

RAC consumers have limited opportunity to select a RAC facility which meets their restorative and wellbeing needs as the quantity and type of allied health provided in each RAC facility is not transparent. These barriers cause restorative and wellbeing services to be inequitably distributed in the RAC sector, provided in low quantities, financially unobtainable for some RAC residents, and non-transparent to the RAC consumer.

To improve restorative and wellbeing care accessibility and transparency in RAC, the Policy Brief recommends that the Australian government should: amend the minimum standards to support continuous care delivery and equitable access, consolidate allied health funding and care provision within the RAC sector, trial workforce employment strategies to improve multidisciplinary care, and collect, report, and evaluate data on allied health services in RAC with consumer input.

Background

Restorative and wellbeing care

The terms restorative and wellbeing care are used to describe care that focuses on maintenance or improvement in function and quality of life. Restorative and wellbeing care often includes targeted physical, social, and cognitive stimulation and the assessment and management of faculties which support participation such as hearing, cognition, balanced nutrition, mental health, eyesight, oral health, balance, musculoskeletal function, and speech.

The provision of restorative and wellbeing care is most useful to people living in aged care facilities, where residents are often living with degenerative medical conditions. For example, more than one in two residents in RAC have a diagnosis of dementia, and one in three have high care needs (Gibson, 2020).

Internationally, the provision of restorative and wellbeing care in residential aged care (RAC) has been shown to improve resident outcomes, including:

• reducing the incidence of falls (Meulenbroeks et al., 2024a),

• improving resident satisfaction in meals and reducing the risk of malnourishment (Meulenbroeks et al., 2022a),

• improving mood and behaviour and reducing the use of psychotropic medications (Bakerjian et al., 2020).

All health professional disciplines operating in RAC play an important role in the provision of restorative and wellbeing care as part of a broader multidisciplinary team. However, services outside of nursing and medicine—allied health services—play a pivotal role in the provision of wellbeing and restorative services in RAC (Royal Commission into Aged Care Quality and Safety, 2021a).

Allied health workforce in RAC

In Australia, each state and territory jurisdiction, peak body, professional group, and regulatory board has its own definition of allied health which is used to refer to more than 60 different professional groups (Appendix 1). The lack of a universal definition both here in Australia, and internationally, complicates international and national quality, quantity, and workforce benchmarking. However, the Australian Health Practitioner Regulation Agency (Ahpra) and all Australian state and territory governments consistently classify occupational therapists, physiotherapists, podiatrists, psychologists, and speech pathologists as allied health professionals.

In 2020 approximately 14,000 allied health professionals were working in Australian RAC (DoH, 2020). As many allied health professionals work-part time in RAC, this represents approximately 6,000 full-time equivalent positions. Allied health assistants (30%), physiotherapists (28%), and diversional therapists (22%) make up approximately 80% of the full-time equivalent allied health workforce in Australian RAC (DoH, 2020).

The proportion of allied health professionals in the RAC workforce is declining. In 2012, allied health workers held 5.3% of full-time equivalent positions (King et al., 2013) but in

2020 allied health workers held 4.5% of full-time equivalent positions (Department of Health, 2020). A reduction in staff mix limits the quantity of restorative and wellbeing care residents directly receive from allied health professionals; and the restorative and wellbeing care they would have received from a multidisciplinary team.

Restorative and wellbeing care is limited in RAC

The quantity of allied health service delivered, including recreation time, per resident per day is a key approximate for the quantity of restorative and wellbeing care RAC residents receive (Ontario Ministry of Health, 2020). In RAC facilities, the quantity of restorative and wellbeing care provided to residents is dependent on the availability of allied health professionals to deliver the programs of care (Government of New Brunswick, 2012).

Australian RAC residents receive low quantities of allied health services per resident per day compared to international benchmarks (Eagar et al., 2019). For example, the European Union recommends that RAC residents receive at least at least two 45-minute exercise sessions per week (de Souto Barreto et al., 2016). Canada mandates a minimum of 36-minutes of allied health service delivery per resident per day (Ontario Ministry of Health, 2020).

Submissions to the Australia's Royal Commission into Aged Care Quality and Safety (2018–2022) recommended that a minimum 22-minutes of allied health service delivery per resident per day was required to remain comparable to international benchmarks (Royal Commission into Aged Care Quality and Safety, 2021a). Since 2018, international health systems used to benchmark allied health service provision have increased allied health service provision quantities to 36-minutes and 40-minutes per resident per day, inclusive of lifestyle and leisure activity (DoHAC, 2023b; Ontario Ministry of Health, 2020), while Australia has yet to achieve 22-minutes of the same allied health services per resident per day (DoHAC, 2023e). Although, to date it is unclear, due to limited data collection and analysis, what quantity of allied health care is required in RAC facilities to optimise RAC resident outcomes and health system resources.

In Australia, the quantity of allied health care RAC residents receive is unclear. Nationally, Australian RAC residents may receive approximately 13-minutes of allied health care per resident per day however national allied health data quality is considered to be poor (DoHAC, 2023e). In industry surveys, it was found that each resident received 15-minutes of allied health services per day, with 50% of this time being provided by diversional therapists and/or lifestyle staff (Stewart Brown, 2020). In another survey from 2022–2024, allied health service provision was found to range from 9 to 16 minutes of service provision month to month (Mirus Australia, 2024). However, in this case, the sample size of RAC facilities involved was not specified. The quantity of additional restorative and wellbeing care provided outside of allied health service time in Australian RAC is likely to be low (Parry et al., 2019; Siette et al., 2022).

While Australia has committed to focusing care on restorative and wellbeing, subsequent RAC sector reforms, such as the amendment of the Aged Care Quality Standards, Aged Care Act (DoHAC, 2023d), and the introduction of

the Quality Indicator Program (DoH, 2021b) have not led to expected improvements in restorative and wellbeing care delivery (AHPRA, 2022a). This negatively impacts RAC resident health outcomes given the association between allied health services and RAC resident health outcomes (Meulenbroeks et al., 2022a).

To address this systematic under servicing, greater investment in allied health services in RAC is required to ensure RAC residents can access evidenced-based quantities and a range of allied health services which support function and quality of life (Royal Commission into Aged Care Quality and Safety, 2021a).

Restorative and wellbeing care governance

Limited allied health care requirements in RAC

Australia achieves high-quality aged care by mandating minimum care standards and benchmarking RAC facilities. All providers must comply with minimum quality standards outlined in the Quality-of-Care Principles and Aged Care Act (DoHAC, 2023d) but should strive for high-quality care as measured and published through the Quality Indicator Program (DoH, 2021b).

Yet, the minimum quality standards and Quality Indicator Program in Australia do not protect consistent, minimum provision of restorative and wellbeing care in Australian RAC facilities (AHPA, 2022b).

To remain accredited RAC facilities must provide access to allied health services for day-to-day recreation and higher intensities of rehabilitative therapy as specified in the Quality-of-Care Principles (DoHAC, 2023d). However, the ability to provide access to restorative and wellbeing services does not guarantee that the residents were referred to or receive this type of care in practice as access is not quantified (DoHAC, 2023d).

RAC facilities need to provide restorative and wellbeing care programs to achieve high performance in falls, malnutrition, and quality of life Quality Indicators (Meulenbroeks et al., 2024a; Siette et al., 2022). However, RAC facilities can also achieve high performance in Quality Indicators artificially without providing restorative and wellbeing care (Mukamel et al., 2009). In the United States (US), RAC facilities selected residents without pain over residents who had pain for an available bed after the introduction quality report cards (Mukamel et al., 2009). It is unclear whether Australia's Quality Indicators Program has encouraged perverse behaviour within the Australian RAC sector.

In addition, given Australia's limited history of allied health service data collection it is unclear in current literature what quantity of allied health care, and what type of service, is required to optimise RAC resident outcomes in the Quality Indicator program (Meulenbroeks et al., 2022b). Greater investment in RAC allied health data collection and research is required to determine how RAC providers and decision makers can optimise health system resources to improve RAC resident outcomes.

The impact of inconsistent and low quantities of restorative and wellbeing care

Without mandatory minimum quantities of RAC allied health service provision, Australian RAC residents are receiving unequally distributed, declining or absent quantities restorative and wellbeing care. Approximately three out four Australian RAC facilities report not using any allied health services outside of physiotherapy, speech pathology, podiatry, and diversional therapy/lifestyle and leisure services in the 4th Quarter 2022–2023 RAC financial reports (DoHAC, 2023e).

The appropriateness of intermittent access to certain allied health services requires further exploration and it is unclear whether, over a quarter period, this is approach is suitable, for example in small RAC facilities with healthy

populations. However, restorative and wellbeing services, such as lifestyle and leisure, should be delivered in Australian RAC facilities in continuous and consistent quantities in line with their case mix (DoH, 2022a).

There has also been a decline in the number of allied health services received by Australian RAC residents between 2023–2024 and 2019 (DoHAC, 2021; Eagar et al., 2019). The restorative and wellbeing care Australian RAC residents receive is also believed to be inconsistent and low in quality (AHPA, 2023).

Interrupted service delivery

The absence of mandatory minimum allied health service quantity requirements in Australian RAC permits allied health services, and the restorative and wellbeing care they provide, to be put on hold or scaled back during times of resource stress.

For example, during the COVID-19 pandemic and following the introduction of aged care sector reforms, Australian RAC facilities were able to reduce and out on hold restorative and wellbeing programs run by allied health professionals (Meulenbroeks et al., 2023a; Meulenbroeks et al., 2023b; Royal Commission into Aged Care Quality and Safety, 2021a). Health professionals report that placing a hold on restorative and wellbeing care negatively impacts RAC resident physical function and behavioural and psychological symptoms of dementia (Meulenbroeks et al., 2023b).

Health system resources

The lack of minimum RAC allied health care quantity standards indicates a poor use of health system resources, as Australian RAC residents are not able to achieve intended improved health outcomes when restorative and wellbeing services are delivered inconsistently. For example, in order to effectively prevent falls, older adults require exercise programs of at least two hours a week for six months (Sherrington et al., 2008). RAC residents will not achieve the effective dose required to prevent falls if it is service delivery is put on hold, as has occurred in Australian RAC facilities in the past, and yet the RAC facility will still need to bear the cost of running the program.

The sustainability of the Australian RAC allied health workforce is compromised by inconsistent allied health service delivery in RAC facilities (AHPA, 2022b; Meulenbroeks et al., 2023b). Allied health professionals have reported increased intent to leave the RAC workforce due to job insecurity during system stressors such as in the wake of service disruptions from the COVID-19 pandemic and the aged care funding transition in October 2022 (AHPA, 2022b; Meulenbroeks et al., 2023b).

Examples of allied health service disruption

COVID-19

More than one in two allied health professionals reported pausing allied health service delivery during the pandemic in a survey of over 100 RAC allied health professionals. The pause in care delivery reportedly persisted for months in some circumstances (Meulenbroeks et al., 2023a; Meulenbroeks et al., 2023b; Royal Commission into Aged Care Quality and Safety, 2021a).

Sector reform

Australian National Aged Care Classification (AN-ACC): Nearly one in two allied health professionals working in RAC reported that the hours they worked in RAC decreased following the introduction of the AN-ACC in October 2022 in a survey of approximately 300 allied health professionals (AHPA, 2022b).

200-care minutes: Residents received 30% less allied health services per day in the month following the introduction of 200 mandatory care minutes in September 2023 compared to the previous month (Mirus Australia, 2023).

High turnover of the RAC workforce is thought to be costly to the health system. Not only is it expensive to continuously recruit and train new staff, but there are also costs to manage the unintended consequences associated with high staff turnover, such as low care quality (Zheng et al., 2022).

International and national solutions

Internationally, countries have moved to protect the time dedicated to restorative and wellbeing care by protecting allied health staffing or minimum quantities of service provision. The US protects minimum service requirements by mandating that facilities employ allied health services to be accredited.

For example, US RAC facilities of greater than 120-beds must employ a full-time social worker to remain accredited by Medicaid (Bern-Klug et al., 2018). However, as two thirds of US RAC facilities have less than 120 beds, and very large facilities are not required to hire more than one full-time social worker, there is inequity in the protection of minimum social service requirements and quantity of wellbeing care RAC residents receive (National Association of Social Workers, 2022).

Two Canadian provinces mandate 36- and 40-minutes per resident day of restorative and wellbeing activity delivered by allied health professionals (e.g., physiotherapists, occupational therapists, recreational therapists) (DoHAC, 2023b).

RAC resident health outcomes and RAC service quality does improve with higher daily quantities of allied health input (Meulenbroeks et al., 2022a). However, the Canadian mandatory allied health quantities are arbitrary as with current RAC evidence it is unclear what intensity of allied health input is required to optimise RAC resident outcomes, health system resource use, and restorative and wellbeing care provision by the multidisciplinary team (Meulenbroeks et al., 2022b).

Additionally, RAC residents may be harmed, at a cost to the RAC system, if care minutes are set too high. For example, prior to 2019, US RAC facilities delivered ultra-high doses of physiotherapy and occupational therapy (>500 minutes a week) to RAC residents in their last days of life due to a financial incentive to provide 720-allied health care minutes per week (Temkin-Greener et al., 2019).

Australia has received several recommendations in the past to protect the minimum quantity of restorative and wellbeing care residents receive in RAC. An Australian report, commissioned to inform the design the AN-ACC during the Royal Commission into Aged Care Quality and Safety, recommends setting a minimum requirement for daily allied health and lifestyle and leisure service

provision in RAC: 22-minutes per resident per day (Eagar et al., 2020).

However, this recommendation was not put forward in the final Royal Commission recommendations which instead recommended, to protect the quantity and breadth of service delivery, that Australian RAC facilities should employ 10 different allied health professions: an oral health practitioner, mental health practitioner, podiatrist, physiotherapist, occupational therapist, pharmacist, speech pathologist, dietician, exercise physiologist, and a music or art therapist (Royal Commission into Aged Care Quality and Safety, 2021b). This recommendation was accepted in-principle by the Australian Government (DoH, 2021a) however it has not implemented as of 2024 and would require significant Government resourcing to achieve.

A quantifiable measure of allied health service delivery, either through employment or care quantity, is a consistent feature of past national recommendations and international solutions to secure consistent quantities of allied health care in RAC. Notably, past recommendations have focused on measures of allied health service activity alone, rather than measures of allied health service activity in the context of optimising RAC resident outcomes and health system resources. Further research is required to inform the recommendations on the quality of allied health care required in RAC to support RAC resident outcomes.

In 2024, with current allied health RAC resourcing and limited knowledge on outcome-driven allied health service delivery, Australia should reinforce minimum standards outlined in the Quality-of-Care Principles to support evidence-based allied health service delivery and equitable access. To achieve this, the minimum care standards should be amended to clear, quantifiable metrics which require RAC facilities to:

- provide more than zero hours per resident per day of maintenance restorative and wellbeing care such as leisure and lifestyle, to minimise the stop-start of day-to-day services, and
- demonstrate count data on resident referral to subsidised post-acute and non-post-acute restorative care programs.

Resource allocation and comprehensive service provision

Australia does not subsidise all allied health services to provide essential restorative and wellbeing care in RAC facilities. Services directly subsidised under the MBS are limited to (DoHAC, 2023c, 2024b):

- Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers,
- audiologists,
- chiropractors,
- diabetes educators,
- dieticians,
- exercise physiologist,
- dieticians,
- mental health services provided by Aboriginal and Torres Strait Islander practitioner, occupational therapists, psychologists, and social workers,
- occupational therapists,
- osteopaths,
- podiatrists,
- pharmacists,
- psychologists, and
- speech pathologists.

However, the type of services listed under the MBS has not been updated to cover other, evidence-based, types of allied health care in RAC; oral health care and social, creative, music, and routine physical activity.

The benefits of oral health care and social, creative, music and physical activity in RAC settings:

- Oral health services improve resident pain and quality of life, reduce infection rates, and avoid unplanned hospital visits and general practitioner (GP) appointments (The University of Newcastle, 2023).
- Music and creative activity can improve resident mood and quality of life (Emblad, 2021; Mileski et al., 2019).
- Routine physical activity improves resident health, including cardiovascular fitness, and function including mobility and balance (Lewis et al., 2020).
- Facilitated social and leisure activity improve loneliness, resident mood, depression, and quality of life (Behrendt et al., 2023).

It is unclear whether the AN-ACC resources allied health professionals that are not listed on the MBS in a consistent manner as the quantity and type of allied health services subsidised by the AN-ACC in RAC in practice is not reported (AHPA, 2022a).

In Australia, RAC facilities can use AN-ACC funding allocations, received as a total pool of funds, to provide any restorative and wellbeing service that does not duplicate MBS items or commonwealth subsidised restorative programs to suit their RAC population (DoHAC, 2022).

However, Australian RAC standards are not clear on which restorative and wellbeing services RAC facilities must provide using the AN-ACC funding (AHPA, 2022a).

This creates RAC resident affordability and access barriers to essential allied health services not explicitly listed on the MBS—oral health care and social, creative, music, and physical activity—as they may not be subsidised by RAC facilities using AN-ACC funding allocations.

Services with uncertain funding

Oral health care in Australian and international RAC

Public dental clinics are the only subsidised oral health care available nationally to Australian RAC residents. Practically, however, they are often not accessible to RAC residents due long waiting lists (ADA, 2019). Accessibility is also impacted by transportation costs as residents are unable to claim the transport and support care costs incurred attend an off-site appointment (ADA, 2019). The median time South Australians on the public dental clinic waitlist wait is four months while the median public dental clinic wait time for Tasmanians is 3.5 years (Productivity Commission, 2023).

By comparison, the average Australian RAC resident lives in a RAC facility for less than two years (AIHW, 2023a). This means that if an Australian RAC resident could afford the transportations costs, they may exit RAC prior to reaching the top of a waiting list for a subsidised dental appointment at a public dental clinic. This can cause RAC residents to live with poor health including pain and low quality of life (ADA, 2019).

Australia does not subsidise oral health care delivered at the RAC facility (Dementia Australia, 2023). Oral health care, delivered in the RAC facility, is superior to external clinic visits for RAC residents as it less stressful than attending an off-site dental office. This is particularly the case for RAC residents with dementia, as is not limited by RAC resident physical mobility and transport (Dementia Australia, 2023).

Without subsidises for on-site oral health care, Australian RAC residents face financial barriers when accessing oral health care which is appropriate and catered to their needs (Dementia Australia, 2023). The financial barriers in accessing at home oral health care limit up take of at home oral health care. Three out of four Australian RAC facilities do not receive regular on-site visits from a dental professional (Webb et al., 2013).

Case study: costs incurred by Australian RAC residents accessing at home oral health care.

Mr White does not have natural teeth: a condition that impacts two in three Australian RAC residents (AIHW, 2000). His existing dentures require replacement. Aged care guidelines recommend that dentures require replacement every 2–5 years (Department of Human Services, 2002). Mr White also has dementia and finds new environments distressing; it would be a significant burden on him and logistically challenging Mr White's care staff and family, who would need to accompany him, to attend an off-site dental appointment.

Mr White now faces a choice of:

1) Paying up to AU$4,000 out-of-pocket for a new set of dentures fitted for him at home at his facility, or

2) Forgoing treatment causing him to have poor oral health and difficultly communicating due to ill-fitting dentures, both of which negatively impact his quality of life

Note: Case study is based off clinical guidelines, RAC resident demographics, and financial barriers reported by consumers to Dementia Australia (Dementia Australia, 2023).

Australian trials of subsidised on-site oral health services in RAC facilities have demonstrated that this model of care is beneficial to health system and resident outcomes (ADA, 2019). On-site oral health service provision in RAC settings can also engage aged care staff and can improve routine oral health practices within the RAC facility (Dementia Australia, 2023). This should be subsidised and implemented in Australian RAC facilities.

Case study: Senior smiles-at home oral health service delivery in New South Wales (NSW) RAC facilities.

Senior Smiles is an ongoing RAC oral health assessment and treatment program based in Newcastle, NSW which has demonstrated a reduction in infections, GP visits, mortality, hospital admissions, and improvement in nutrition and quality of life in RAC residents.

A cost-effectiveness study of Senior Smiles found that every dollar spent on the program produced $2.40 in benefits for the health care system and an additional AU$3.18 in social benefits (The University of Newcastle, 2023).

Health system-wide resourcing of on-site oral health care in RAC settings has been achieved by other countries internationally. Examples are limited, but include:

•Japan: Japanese RAC residents can access subsidised on-site oral health care through long-term care insurance which covers all Japanese residents over 65 years old. However, due workforce limitations, few professionals and unwillingness to work in RAC, in practice, few facilities delivery on-site oral health care (Jiang et al., 2021; Zaitsu et al., 2018).

•Hong Kong. RAC residents living in Hong Kong receive oral health outreach care through a partnership of government general revenue and charity organisations allowing the resident to access dental check-up, emergency treatment, scaling, and pain relief treatment and on-site oral health education seminars to the older adult, family, and care staff without charge (Jiang et al., 2021).

Social, leisure, music, creative, and physical activity in Australian RAC

Australian funding structures (AN-ACC and MBS) do not fund the breath of service types and resources required to provide meaningful choice restorative and wellbeing care in RAC facilities. Australian RAC minimum standards require RAC facilities to provide social activity, which often run by lifestyle officers, without additional cost to the RAC resident using the AN-ACC (DoH, 2022a).

Social activity provided in RAC can include social clubs, such as knitting or book club, and holiday events, such as a resident event for Melbourne Cup Day (Huang et al., 2024). However, RAC resident choice in meaningful social activity may be limited as RAC facilities are not required to use AN-ACC funding support costs of community access and additional resources, such as food, for social groups (DoH, 2022a).

Additionally, subsidised social activity in Australian RAC may or may not include music, creative, and physical activity: which are essential to RAC resident wellbeing and important aspects of RAC care as determined by RAC consumers (Meulenbroeks et al., 2024b).

Australia RAC residents are unable to claim for routine music, creative, and physical activity through the MBS as professional groups who commonly provide these services in Australian RAC facilities are not subsidised: diversional therapists and lifestyle staff, allied health assistants, music therapists, and art therapists (DoHAC, 2023c).

The lack clear subsidises for a range of wellbeing care activities limitsconsumer choice in wellbeing activities and causes affordability barriers to diverse and enriching music, creative, social, and physical activity participation.

Case study: RAC residents benefit from social, leisure, music, creative, and physical activity -:

Resident: Ms Black, an Australian RAC resident, has a diagnosis of dementia: this affects more than one in two Australian RAC residents (Gibson, 2020). She at times exhibits behaviours which are challenging for her care staff to manage such as wondering and agitation.

Restorative and wellbeing care: To manage Ms Black's agitation, without adding to her medication regime, Ms Black's personal preferences and capabilities are assessed by an occupational therapist[a]. She is set up with independent meaningful activities her room. Ongoing participation in independent meaningful activity is encouraged by her care staff.

To manage her agitation, Ms Black also participates in a weekly music therapy program, led by a music therapist, and assisted by allied health assistants, and a twice weekly social activity program[b], facilitated by diversional therapy lifestyle and leisure staff, where she can socialise with residents.

To reduce the risk of falling while wondering, Ms Black participates in a twice weekly exercise program which focuses on fall prevention. The exercise program was designed by a physiotherapist[a] but is routinely run by allied health assistants.

Enablers: Ms Black can access restorative and wellbeing care services because at her RAC facility charges an out-of-pocket additional daily fee of $65 per resident per day, charged on top of the basic daily fee, is used to provide a range of allied health services and additional resources to support the services such as food at social events and outing costs.

Notes:

[a]Australian RAC residents can claim up to subsidised five appointments per calendar year for these professionals (DoHAC, 2023c).

[b]Australian RAC facilities cannot charge for delivering recreational activity which meets the resident's clinical needs as this should be subsidised by the AN-ACC (DoH, 2022a). RAC facilities can however charge for additional care provided in excess of clinical needs (DoH, 2022a). It is unclear how clinical need and above clinical need is determined. Diversional therapy and lifestyle staff speculate that when there are competing needs for resources in Australian RAC the judgement of clinical need does not consistently protect resources required to provide lifestyle and leisure activity by skilled staff in RAC facilities causing RAC facilities to charge residents additional fees to provide consistent services (Iovino et al., 2024).

The range of wellbeing resources funded for adults over 65 in Australian RAC is not equivalent to resources available to for adults with a disability under the age of 65 (NDIS, 2023), even though more than 9 in 10 people living in RAC live with a profound disability (ABS, 2018).

Providers and Australian adults under 65 with a disability can claim for services and support to participate in physical, music, creative, and a choice of social activity from designated social and recreation funding allocations if it aligns with the persons care plan and goals under the National Disability Insurance Scheme (NDIS) (NDIS, 2023).

Adults over 65 years old are unable to access consistent subsidised funding for these same services due to non-specific funding in the AN-ACC, and non-funding by the MBS. The age-based inequity in service choice for people living with physical and mental disability should be rectified to give RAC residents choice in restorative and wellbeing care activities which suits their care goals.

Resource allocation and effective quantities of restorative and wellbeing care

Day-to-day wellbeing care

Financial barriers prevent Australian RAC residents from being able to access recommended quantities day-to-day wellbeing and restorative care in Australian RAC settings. The Australian Government directly subsidises approximately 20-seconds of allied health service delivery per resident per day through the MBS (Table 1) which is far below the recommended minimum allied health service provision in Australian RAC, 22-minutes per resident per day, and international benchmarks (DoHAC Care, 2023c; Eagar et al., 2019).

Table 1. Allied health funding sources and the quantity of allied health care they support in Australian RAC (Department of Health and Aged Care, 2022, 2023c, 2024b; My Aged Care, 2024).

Funding source	Funding scheme	Quantity of allied health care supported
Subsidised	MBS	Five appointments of at least 20 minutes per calendar and one medication management review in a calendar year.
	AN-ACC	Unclear.[1]
Self-funded	Additional service daily fee	At the discretion of the RAC facility.
	Individual cost	At the discretion of the RAC resident.[2] It is unclear how many Australian RAC residents can claim individual costs under private health insurance.

Notes:

[1] Allied health service provision costs are not considered in AN-ACC RAC funding allocations. However, Australian RAC facilities can use the funds allocated by the AN-ACC to provide restorative and wellbeing services. Allied health professionals speculate that Australian RAC facilities prioritise of use AN-ACC funds to provide mandatory service requirements, such as care minutes, and use any remaining funds, if they exist, on restorative and wellbeing care services.

[2]Some RAC residents may be able to claim self-funded allied health service costs from private health insurers if they have ancillary cover.

Additional subsidised quantities of allied health care are available through the AN-ACC. While it is unclear how much additional allied health care is subsidised through the AN-ACC, the quantity subsidised likely falls below evidence-based quantities as total, subsidised and non-subsidised, allied health does not reach these targets (DoHAC, 2023e). The financial barriers limit equitable RAC resident opportunity to achieve positive health outcomes associated with evidence-based doses of restorative and wellbeing care.

Case Study: disparity between subsidised allied health care quantities and evidence-based quantities for RAC residents.

Case: Mr Green, an Australian RAC resident, has a diagnosis of Parkinson's Disease. Mr Green's medical history puts him at risk of falling.

To manage his fall risk, Mr Green participates in a regular exercise program. Mr Green needs to participate in at least 1.2 hours of tailored balance and resistance exercise per week (10.3 minutes per resident per day) to reduce his risk of falling (Hewitt, 2019). Australian RAC trials with similar doses have demonstrated a 45% reduction in the incidence of falls and if scaled to and implemented in all Australian RAC facilities may provide AU$27,000,000 in cost benefits due to the reduced use in acute care resources (Hewitt, 2019; Hewitt et al., 2019; Mak et al., 2022).

The financial barriers to accessing evidence-based quantities of care: The estimated annual cost of running evidence-based quantities of Mr Green's falls program in Australian RAC is $AU381 per resident. A once-off equipment cost to run the service of $264 at the inception of the program is also required.

Annualised fall prevention program cost breakdown (Hewitt et al., 2019)

Item	Cost per resident per day (AU$)
Equipment costs	264*
1 x physiotherapist	0.40
2 x activity officers	0.64
Total cost per annum per resident	383.31
Total cost per annum per resident, inclusive of equipment charge	647.31

**once-off fee at program inception: The cost of equipment may be subsidised by the AN-ACC if the equipment is considered standard communal equipment for lifestyle and leisure activity (AIHW, 2023b).*

Mr Green may be able to claim the cost of an initial physiotherapy consultation on entry to the program through the MBS, equating to approximately 3-seconds of subsidised care per day over a year. However, he is unable to claim any further costs as the MBS does not subsidise group-based therapy for these professions (DoHAC, 2023c).

It is unclear, and speculated to be unlikely, that Mr Green's RAC facility can subsidise the cost of the falls prevention program significantly further through funds receive through the AN-ACC; the total quantity of daily care required, 10.3 minutes, is higher than current quantities of care delivered in Australian RAC facilities and many Australian RAC providers do not operate at a profit (AHPA, 2022a; DoHAC, 2022). This leaves Mr Green out of pocket up to $589 per year, when factoring in equipment costs, to receive restorative and wellbeing care which would benefit his health outcomes and health system sustainability. The cost is charged on top of his existing aged care payments and expenses incurred to receive other services which will preserve his function.

Notes: The scenario and figures presented are based off the economic evaluation of the Sunbeam trial, financial reports, AN-ACC funding, and MBS items (AIHW, 2023b; DoHAC, 2023c; Hewitt, 2019; Hewitt et al., 2019; Mak et al., 2022).

High-intensity restorative care

High-intensity restorative care is critical to improve functional outcomes after an acute medical episode, such as a broken hip (Crotty et al., 2019). However, high-intensity restorative care in RAC populations is not cost-effective by standard economic measures due to high mortality in the population regardless of receiving restorative care (Crotty et al., 2019).

Despite the cost-ineffectiveness of high-intensity restorative care, it is essential to give RAC residents tailored opportunities to improve their function after an acute episode as not all RAC residents have a limited life expectancy and RAC residents with limited life-expectancy still need functional capacity to maintain quality of life (Crotty et al., 2020).

However, Australia does not resource dedicated short-term high-intensity restorative care programs for RAC residents (DoH, 2019, 2022b). In 2024, Australian RAC residents are eligible to receive high-intensity short term restorative care, following hospital admission, through the Transitional Care Program (TCP) which provides up to 12 weeks of nursing and medical support, personal care, and allied health services (DoH, 2019), or in-patient rehabilitation (Mitchell et al., 2021).

Nevertheless, in practice, Australian RAC residents rarely access subsided high-intensity restorative care programs due to functional and cognitive program eligibility requirements (DoH, 2019; Mitchell et al., 2021) (Figure 1).

Australian RAC residents are also unable to consistently access short-term high-intensity restorative care at their RAC facility. Two in five Australian RAC facilities do not provide high-intensity restorative care on site as they are not required to under Quality-of-Care Principles and the provision of this care is not subsidised by the Australian Government (DoHAC, 2023c; DoH, 2022b).

To resource high-intensity restorative care RAC facilities may charge an additional fee, often as an ongoing daily fee for the length of the RAC admission at the RAC facility (DoH, 2022a). The structural and financial barriers to high intensity restorative care cause some residents to miss out on opportunities to improve their function after an acute episode (DoH, 2022b). Australia requires a simpler, consistent approach to RAC resident restorative care post-hospitalisation.

Case Study: *Barriers to accessing high-intensity care post hospitalisation.*

Ms Brown, a RAC resident with dementia, broke her hip in a fall. Ms Brown was admitted to hospital, but she is now medically stable and ready to leave hospital.

Prior to her hip fracture, Ms Brown could walk 20 metres with a walker under supervision and required light assistance showering and dressing. Following her hip fracture, Ms Brown now requires heavy assistance from two people and a stand-up lifter to transfer to a chair and full assistance for toileting, showering, and dressing.

Ms Brown, and her family, would like her to participate in restorative care program to regain her function. The map below describes the pathways Ms Brown used and failed to access high intensity restorative care following her broken hip. After exhausting all pathways, Ms Brown was discharged back to her RAC facility with routine nursing care.

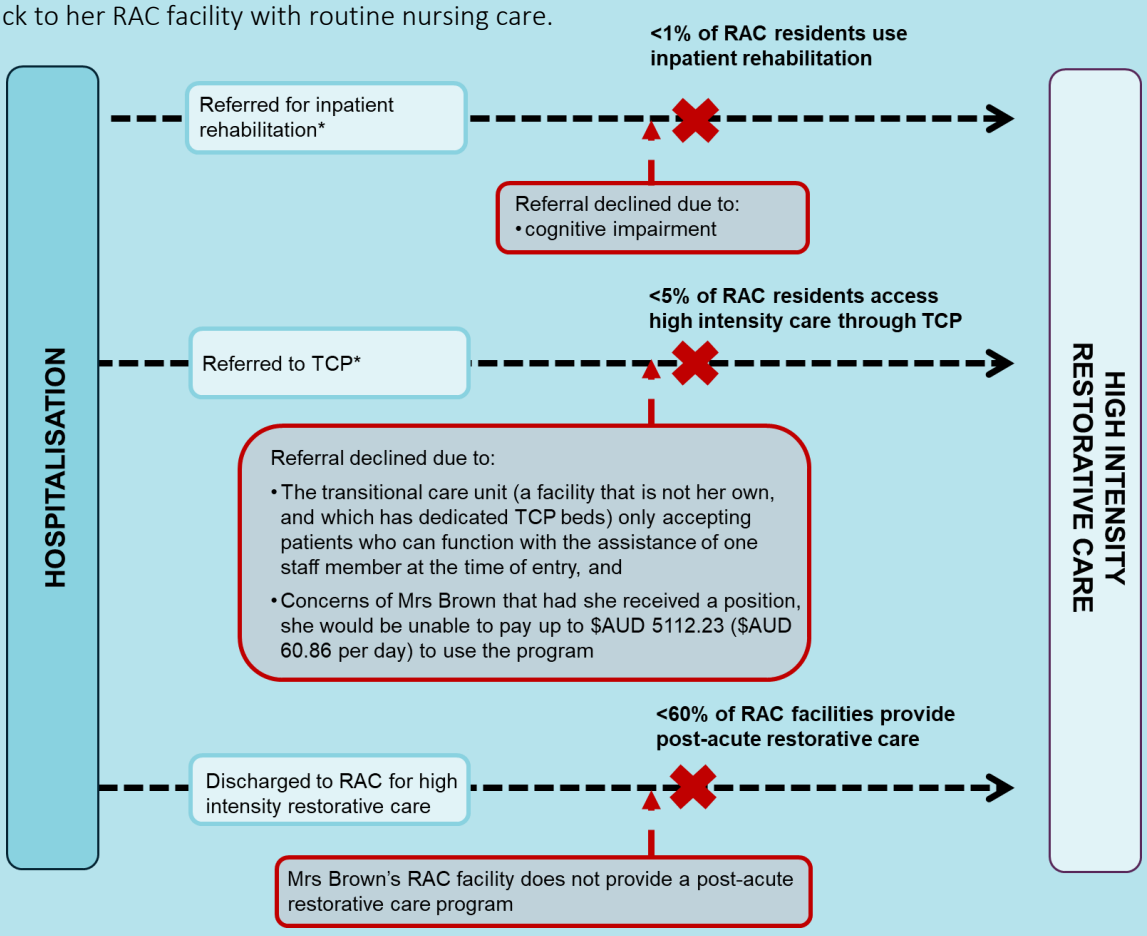
<1% of RAC residents use inpatient rehabilitation
HOSPITALISATION
Referred for inpatient rehabilitation*
Referral declined due to:
• cognitive impairment
<5% of RAC residents access high intensity care through TCP
Referred to TCP*
Referral declined due to:
• The transitional care unit (a facility that is not her own, and which has dedicated TCP beds) only accepting patients who can function with the assistance of one staff member at the time of entry, and
• Concerns of Mrs Brown that had she received a position, she would be unable to pay up to $AUD 5112.23 ($AUD 60.86 per day) to use the program
<60% of RAC facilities provide post-acute restorative care
Discharged to RAC for high intensity restorative care
Mrs Brown's RAC facility does not provide a post-acute restorative care program
HIGH INTENSITY RESTORATIVE CARE

*Figure 1: Barriers to accessing high intensity care post hospitalisation.*indicates subsidised high intensity care program.*

Notes: Eligibility for private and public inpatient rehabilitation varies throughout Australia (Mitchell et al., 2021). For example, some inpatient facilities explicitly exclude RAC residents, in other rehabilitation facilities, while RAC residents may be eligible, they are declined on various other factors such as their cognitive capacity and current or baseline physical function (Mitchell et al., 2021).

High intensity care programs at the RAC facility following are not subsidised (DoHAC, 2023c). Australian RAC facilities are unable to charge for a professional assessment and time an appropriate professional took to design a restorative care program for the individual resident (DoHAC, 2023c). However, Australian RAC facilities can charge for the day-to-day delivery of the restorative care program following an injury, surgery, or trauma (DoH, 2022a).

The case study was based off results from Australian university led study (Mitchell et al., 2021). Numeric values presented are sourced from National Australian Government documents and calculated as a percentage using the total RAC population of the relevant year (DoH, 2019, 2022b).

Within the RAC resident population, certain geographic locations and vulnerable cultural groups residents have inequitable opportunities to access subsidised high-intensity restorative care programs due to eligibility requirements (DoH, 2019). For example, four out five TCP places in Western Australian (WA) are used by RAC residents, whereas one in fifty TCP places in the Northern Territory (NT) are used by RAC residents. The WA TCP accepts RAC residents who are not able to bear weight through their limbs and require heavy physical assistance, whereas other states exclude these residents (DoH, 2019). This causes inequity in access to subsidised restorative care and opportunity to functionally improve following an acute event with the RAC population throughout Australia.

Aboriginal and Torres Strait Islander older adults are also proportionally less likely to use the TCP Program (DoH, 2019). An evaluation of the TCP program speculated that the TCP program was not accessible to Aboriginal and Torres Strait Islander older adults because they are less likely to present to hospital than their non-Aboriginal and Torres Strait Islander counterparts causing them to be ineligible for the program (DoH, 2019). The inequity experienced within RAC populations and associated with access to high intensity restorative care must be addressed (DoH, 2019).

Australian RAC residents require nationally consistent, subsidised access to high-intensity restorative care that is equitable with opportunities community-dwelling and cognitively intact adults receive (Crotty et al., 2020; Mitchell et al., 2021). Equitable access to high-intensity restorative care for RAC residents is an international issue, however some countries have implemented strategies to deliver this type of care.

For example, in Canadian RAC facilities, service provision is dependent on resident factors such as a recent acute episode; and allied health professionals may deliver subsidised high-intensity restorative care by utilising high overall average, mandated care time to focus care on residents with higher clinical need than others (Meulenbroeks et al., 2022a).

In the US, Medicaid-certified RAC facilities may deliver subsidised high-intensity restorative care to RAC residents if it is included in

resident set goals of care under the Patient Driven Payment Model, introduced in October 2019 (Center for Medicare Advocacy, 2019).

Australia should also consistently and clearly subsidise short-term high-intensity restorative care, that is available regardless of hospitalisation, in RAC facilities to give RAC residents opportunity to improve their function following an acute event.

The funding structure for short-term restorative care in RAC should be simplified under AN-ACC so that administrators, providers, and RAC residents are not burdened by the complexity of avoiding double-dipping into Commonwealth funding schemes.

Allied health workforce structure and multidisciplinary team activity

Engagement of allied health professionals

Multidisciplinary team care in primary care settings improves skill sharing across care teams (Healthcare Improvement Scotland, 2023). Allied health professionals advocate that skill sharing is particularly relevant in the Australian RAC setting; with the enhanced collaboration with allied health professionals helping to build the capacity and cross-disciplinary skill of the aged care workforce, as well as helping to centre all care activities around the provision of restorative and wellbeing care (AHPA, 2020).

However, the high turnover and short-term contract employment of the allied health workforce in Australian RAC limits opportunities for allied health professional to consistently communicate- or work to achieve a common goal with RAC providers and the broader RAC workforce (multidisciplinary practice).

One in two allied health professionals in Australian RAC are employed through casual or contracted through third parties and almost third of the allied health workforce leaves their position within a 12-month period (DoH, 2020). This exit from the RAC allied health workforce is reportedly caused by a variety of contemporary and long-term factors such as the impact of the COVID-19 pandemic, job security, remuneration lower than other sectors, dissatisfaction with work environment, and limited career opportunities (Meulenbroeks et al., 2023b).

While the issue of workforce exit has not been extensively researched in Australian RAC settings, allied health professionals report that the transient allied health workforce in RAC limits the development of multidisciplinary networks and practice in Australian RAC facilities (Meulenbroeks et al., 2023b).

There are limited exemplars of, - and high-quality evidence on - multidisciplinary care in Australian or international RAC settings (DoH, 2022b). Nevertheless, multidisciplinary team care is considered gold standard practice in the care of older adults with complex care needs across primary and acute health care settings, as it yields improved resident and health system outcomes (Ellis et al., 2011; Garrard et al., 2020).

Multidisciplinary care in primary care settings has been shown to reduce hospital admissions, improve patient function, decrease dependency and care service use, and improves medication appropriateness (Mitchell et al., 2008). The addition of multidisciplinary care in primary care settings also has no negative impact health care costs (Healthcare Improvement Scotland, 2023) suggesting that multidisciplinary care could be applied to Australian RAC settings to improve resident outcomes without increasing net costs.

International and national practice recommendations

Consistent relationships between health professionals, such as allied health professionals and the remainder of the RAC workforce, are an important facilitator in multidisciplinary team activity in health care settings (Healthcare Improvement Scotland, 2023).

Dutch RAC is frequently described as highly multidisciplinary, providing high quantities of restorative and wellbeing care by international standards with allied health and care staff frequently working in teams towards a similar goal and being located at the same RAC facility (De Boer et al., 2007).

Multidisciplinary care in Dutch RAC facilities has resulted in improved health outcomes for residents (Leontjevas et al., 2013; Pieper et al., 2016). In these multidisciplinary care settings wellbeing interventions involving physiotherapy and psychology, resident psychological and behavioural health outcomes and reduced polypharmacy are observed (Leontjevas et al., 2013; Pieper et al., 2016).

In-house hiring of allied health personnel by RAC providers has been recommended as a method of facilitating the multidisciplinary activity in Australian RAC (Royal Commission into Aged Care Quality and Safety, 2021b). Australian RAC allied health professionals also advocate that in-house hiring of allied health professionals by RAC facilities is mechanism to directly instil restorative and wellbeing care within the culture of Australian RAC facilities (Meulenbroeks et al., 2023b).

However, the success of co-location as a method to facilitate multidisciplinary practice is often dependent on many other factors, including the policy environment and physical design of RAC facilities (Bonciani et al., 2018).

The Australian Government has committed to strengthening consistent relationships between pharmacists, who are allied health professionals who support restorative and wellbeing care, and RAC facilities and staff without in-house hiring of professionals (DoHAC, 2023a). The 2023 Commonwealth Budget included funding to place community pharmacists on-site at local RAC facilities (DoAHC, 2023a).

The same support for strengthening RAC workforce relationships with RAC providers and staff should be trialled, evaluated for its effect on RAC resident health and care quality outcomes, and extended to other essential allied health services such as oral health practitioners, mental health practitioners, podiatrists, physiotherapists, occupational therapists, speech pathologists, dieticians, exercise physiologists, and music or art therapists.

Transparency of restorative and wellbeing care

Quality indicators

As of 2024, consumers are unable to access information about those RAC facilities providing high quantities, and a broad variety of allied health services. This prevents consumers making informed choices about the type of RAC that would best suit their own restorative and wellbeing needs and care goals (DoHAC, 2023b; Meulenbroeks et al., 2024b).

This lack of transparency has been acknowledged by the Australian Government, who has subsequently committed to extending the Quality Indicator program to include two additional quality indicators:

•The quantity of allied health services, and

•The quantity of lifestyle and leisure services (DoHAC, 2023b),

Internationally, no health systems have implemented an allied health quantity Quality Indicator. For example, the US and Canada, report on the quantity of care provided by each allied health profession but the data is not available by facility for health consumers (DoHAC, 2023b).

Therefore, there is limited guidance for the development an application of an allied health quantity Quality Indicator in the Australia's RAC sector. As of 2024, the final design of the Quality Indicator has yet to be determined, however, a proposal is publicly available (DoHAC, 2023b).

Challenges and solutions

Planned allied health Quality Indicators will only reflect the total quantity of allied health and lifestyle care and therefore are unlikely to facilitate consumer choice.

Allied health is a broad term and in practice the health professionals in this group have little in common other than they are not nurses or doctors (Nancarrow & Borthwick, 2021). Accordingly, RAC consumers prioritise different types of allied health professional input based on their needs and preferences (Meulenbroeks et al., 2024b). Therefore, a Quality Indicator of the total quantity of allied health care per resident per day will not meet their information needs (Figure 2).

Australia should act on past recommendations to collect and report on hours per resident per day of every health professional operating in Australian RAC facilities to ensure that a skill mix of health professionals is routinely available (Royal Commission into Aged Care Quality and Safety, 2021b). This information should be made available to consumers.

Case study: total allied health time may not represent all information which is important to consumers.

Mr Silver has a significant speech impediment which is caused by Parkinsons disease. He would like to a reside in a RAC facility which provides speech pathology services so that he can manage his impediment, continue to communicate clearly, and maintain his quality of life. However, using the Quality Indicator program all he can see is that Facility A and Facility B provide the exact same quantity of allied health care time. Mr Silver is unsure which facility would suit his needs.

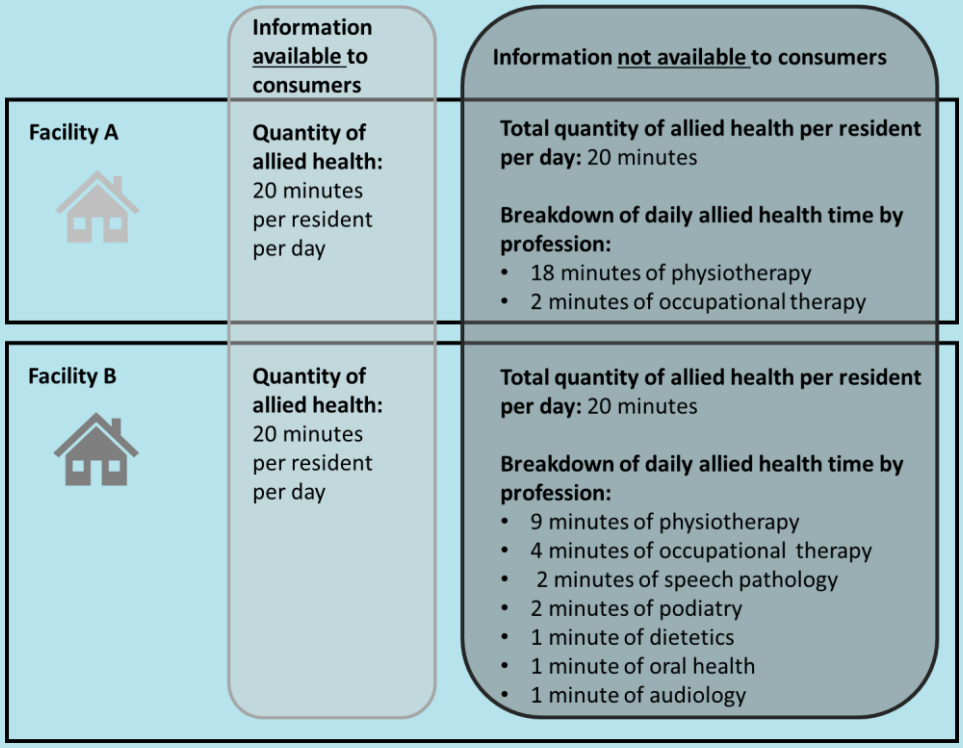
Information available to consumers
Information not available to consumers
Facility A
Quantity of allied health: 20 minutes per resident per day
Total quantity of allied health per resident per day: 20 minutes
Breakdown of daily allied health time by profession:
• 18 minutes of physiotherapy
• 2 minutes of occupational therapy
Facility B
Quantity of allied health: 20 minutes per resident per day
Total quantity of allied health per resident per day: 20 minutes
Breakdown of daily allied health time by profession:
• 9 minutes of physiotherapy
• 4 minutes of occupational therapy
• 2 minutes of speech pathology
• 2 minutes of podiatry
• 1 minute of dietetics
• 1 minute of oral health
• 1 minute of audiology

Figure 2. Quantity of allied health care delivered in two RAC facilities.

Notes: The case study was derived from RAC consumer assumptions expressed at a Consumer Forum on allied health in RAC (Meulenbroeks et al., 2024b).

The Australian Government may limit the allied health Quality Indicator to the quantity of care delivered by university-educated allied health professionals in RAC, while the lifestyle and leisure Quality Indicator may be limited to the quantity of care provided by lifestyle and leisure officers and diversional therapy staff in RAC (DoHAC, 2023b).

However, this segregation may not:

• be easy to understand for consumers who are trying to navigate their care as the role of an allied health professional compared to a

lifestyle and leisure staff member may not be clear (Meulenbroeks et al., 2024b),

• count the quantity of care delivered by relevant allied health professional as allied health assistants, who are not university educated, or lifestyle and leisure staff, may be excluded from the care delivery process (DoHAC e, 2023b),

• be flexible enough to account for future changes in allied health workforce structure as new roles continue to form—such as the addition of allied health assistants to the RAC workforce—and the professionalisation and regulation of professional groups (Nancarrow & Borthwick, 2021).

The segregation of allied health data into allied health and lifestyle and leisure has not been performed by RAC health services internationally (Meulenbroeks et al., 2022a) making international comparison in health services research impossible. Therefore, the structures of siloed allied health data being proposed by Government may not only complicate data collection processes but have few RAC consumer or health system benefits.

Case study: Consumers and allied health quality indicators

In 2025, Ms Grey, an older Australian adult, is looking to enter RAC and is in the process of choosing a facility that would meet her needs. Ms Grey would like to choose a facility that provides a regular music program. She has loved and played music her whole life, continuing to participate in her passion while she lives in RAC would bring her joy and enhance her quality of life. In addition, Ms Grey also would like to choose a facility that provides a fall prevention program. She recently had a stroke which has affected her balance, and she has had several falls, she wants help to do all she can to prevent another fall from happening.

Ms Grey has toured two RAC facilities (Facility A and B). Both the facilities she toured have told her that they provide a regular music and falls prevention program. The quantity of care provided by these programs at the RAC facilities is reflected in the allied health and lifestyle and leisure Quality Indicators.

When Ms Grey goes to compare Quality Indicators between the two RAC facilities, she assumes that the music therapy program is counted in the lifestyle and leisure care minutes and that the fall prevention program is counted in the allied health staff minutes. Afterall, that's how she has experienced these services in the community. Therefore, to meet her needs, Ms Black believes she should look for a facility which provides a balance of allied health care minutes and lifestyle and leisure care minutes.

Ms Grey consults a friend who has experience with Australian RAC regarding her decision. But Ms Grey's friend adds some more confusing information. The friend asked Ms Grey "When you toured the facilities, did you ask what professional groups were responsible for the music and falls prevention programs?". Ms Grey's friend went on to explain, this could impact which Quality Indicators she should be looking at as there is significant cross disciplinary practice in Australian RAC.

After further investigated Ms Grey finds in:

Facility A:

• The falls prevention program is designed by a physiotherapist who reviews the program at the RAC facility for a total of 30-minutes once a year (allied health care minutes). Allied health assistants (who are not counted under allied health care minutes or lifestyle and leisure minutes) run the program for 45-minutes twice per week, and

• The music program is designed and run by a diversional therapist (who has a university degree but is counted in lifestyle and leisure care minutes) for 60-minutes once a week.

Facility B:

• The falls prevention program is designed and by lifestyle and leisure staff (lifestyle and leisure care minutes). The lifestyle and leisure staff run the falls prevention program for 45-minutes twice per week. In addition, a lifestyle and leisure officer who has extensive experience with falls prevention programs, and was trained by a physiotherapist, spends an additional 30-minutes per week reviewing and progressing the goal-orientated resident fall prevention exercises within the program (lifestyle and leisure care minutes), and

• The music program is designed and run by a registered music therapist (who is a university qualified professional and is counted under allied health care minutes) for 60-minutes once a week.

On reflection, Ms Grey is not sure that a separate Quality Indicator for lifestyle and leisure and allied health helped her easily choose a RAC facility to meet her needs as both the music and falls prevention are provided by allied health and lifestyle and leisure staff and not all staff were counted.

In 2030, Ms Grey's younger brother, Mr Grey, is now looking for a RAC facility for himself. Mr Grey shares the same passion for music as his sister, and like her, would like to continue to enjoy and participate in music in his RAC facility.

When Mr Grey visited his sister, Ms Grey, in her RAC facility of choice, her music program was run by a diversional therapist. Ms Grey reported that she valued the music program and diversional therapy input greatly; it was the highlight of her week.

Mr Grey would like to experience a similar service and therefore would like a facility which provides a high quantity of diversional therapy. However, when Mr Grey spoke to the diversional therapist at Ms Grey's facility, they reported that in the last five years diversional therapy had formally adopted a hierarchical structural and were now part of a group of self-regulating allied health professions. This means, in 2030, that lifestyle and leisure staff in RAC settings is comprised of diversional therapists—who require a university education to be registered—and lifestyle and leisure officers who have TAFE qualifications. Previously, in 2025, diversional therapists, often but not always had a university degree.

Mr Grey is unsure what this change means for him when he compares the quantity of care reported in the Quality Indicator program; Does this mean that diversional therapy time, which is what he is

looking for, is counted under allied health quantity as they are now a consistently registered, and university educated allied health profession? Or does diversional therapy time remain under the lifestyle and leisure Quality Indicator where it was categorised in 2025? He isn't sure, so he doesn't end up referring to the Quality Indicators to help him decide a facility that suits him.

Notes: The case study was derived from RAC consumer assumptions on allied health service delivery in RAC expressed at a Consumer Forum (Meulenbroeks et al., 2024b). The case of professionalisation and registration of diversional therapy is based on historical precedent of other allied health professional groups (Nancarrow & Borthwick, 2021).

The challenges in creating two separate Quality Indicators may be worthwhile if the separate data on allied health and lifestyle and leisure activity is meaningful to RAC consumers.

In the 2024 trial of the allied health Quality Indicators, Australian RAC consumers must be extensively consulted to determine whether the segregation of data and definitions used to present allied health Quality Indicators are useful for facilitating consumer choice.

If the separation between allied health and lifestyle and leisure is not meaningful to Australian RAC consumers, the Australian Government should redefine the allied health Quality Indictors to consistently reflect qualifications of allied health professionals. For example, a quality indicator to reflect all university qualified allied professionals and another for all TAFE qualified allied health professionals, as:

- a mix of qualifications is an important metric to track; a balance of university-qualified and TAFE-qualified professionals is required to support patient outcomes and health service reach (Buchan & Law, 2016; Snowdon et al., 2020),
- segregation by qualification is consistent with international allied health data collection (Meulenbroeks et al., 2022a), and
- segregation by qualification may be more tangible to RAC consumers as it is consistent with other RAC data collection such as nursing hierarchies (e.g., registered nurses compared enrolled nurses) (Meulenbroeks et al., 2024b).

Conclusion and recommendations

Australian RAC residents are not receiving the recommended quantities and types of allied health care to support restorative and wellbeing care. This is due to limited and disparate governance, funding, and workforce deployment within the Australia's RAC sector.

The low quantities of care, adversely affect RAC resident health and system outcomes, and create inequities in accessing restorative and wellbeing services, warranting significant reform of allied health service delivery in RAC.

The following recommendations will bring Australia into line with world leading health systems in delivery of restorative and wellbeing care in RAC.

Recommendation 1:

Amend the Quality-of-care Principles to minimise service disruption and support equitable access to available allied health services.

Minimum standards of allied health service delivery should be amended to quantifiable outputs to minimise service disruption of essential day-to-day care and facilitate equity is service accessibility.

Quantifiable minimum allied health service requirements should necessitate all Australian RAC facilities to demonstrate weekly lifestyle and leisure activity above zero hours per resident per day; and count data of RAC resident referral to a restorative care program (post-acute and non-post-acute restorative care) and/or including reasons why referral was not appropriate.

Recommendation 2:

Collapse existing allied health funding in RAC under the AN-ACC.

Australia should consolidate existing allied health service funding for RAC residents under AN-ACC. Australia could achieve this by reviewing existing funding structures and diverting funds which are used by RAC residents to be administered by the AN-ACC.

The Australian Government should also work with private health insurers who also have a responsibility to ensure that privately insured RAC residents can meaningfully access restorative and wellbeing care under their hospital and ancillary cover.

The Australian Government must clarify which allied health services, and how much care RAC facilities are obliged to consistently subsidise. Consolidated Australian allied health RAC funding should not subsidise less allied health care than previous disparate arrangements such as the five subsidised allied health appointments made available in a calendar year, access to a post-hospital reablement program, and the provision of a social program.

The care guidelines should also explicitly specify that RAC facilities can use funds to provide a variety of evidence-based allied health care including, but not limited to: oral health practitioners, mental health practitioners, podiatrists, physiotherapists, occupational therapists, speech pathologists, dieticians, exercise physiologists, music therapists, and art therapists.

Recommendation 3:

Australian RAC facilities should provide a high-intensity short-term restorative care program for RAC residents' post-acute care.

A high-intensity restorative care program should be funded for RAC residents who experience acute trauma, surgery or injury and are hospitalised. This program should be delivered at the RAC facility, short-term, goal-orientated and should be run along the restorative care programs RAC facilities are obliged to temporarily provide using AN-ACC resources. This program should replace the previous out-of-home rehabilitation programs.

Recommendation 4:

Increase RAC resourcing of restorative and wellbeing care to match other Australian populations and evidence-based literature.

Australian government funding should be increased to allow RAC residents dignified choices in social activity that match other populations such as restorative, wellbeing, and community access funding that is available for people <65 years old through the NDIS.

Australian RAC facilities should also receive increased funding support to participate in evidence-based quantities of restorative and wellbeing care. Subsidised quantities of just physical activity must be increased to more than 10 minutes per resident per day.

Recommendation 5:

Resource, trial, and evaluate partnerships between allied health and RAC providers.

The Australian Government should extend support for partnerships between community pharmacists and RAC providers to other allied health professional groups such as oral health practitioners, mental health practitioners, podiatrists, physiotherapists, occupational therapists, speech pathologists, dieticians, exercise physiologists, music therapists, and art therapists. These partnerships should support community allied health professionals to operate on-site at RAC facilities to foster multidisciplinary practice and cross-discipline education. These partnerships should be evaluated to determine the impact on resident outcomes and multidisciplinary team activity in RAC facilities.

Recommendation 6:

Collect and report data on all allied health services in RAC.

Australia should collect data on the hours per resident per day of care delivered by all health professionals operating in every RAC facility using existing quarterly reporting patterns. Data on the type of services and the quantities of care they provide to RAC residents should be monitored to ensure that RAC residents receive an appropriate mix of care types.

RAC consumers should be able to access data on the quantity and type of care delivered each health professional group through the Quality Indicator program. At minimum, RAC consumers should be able to view a list of allied health service types delivered in a facility over a financial year.

Recommendation 7:

Analyse allied health service and resident outcome data to inform evidence-based delivery of allied health services in RAC.

Australia's improved data collection framework should be used to improve evidenced-based use of allied health services in Australian RAC settings. For example,

routine data collection can be used to evaluate what mix of health services, and in what quantity is reasonable to reduce the number of falls in RAC facilities and remain cost-effective.

Findings from research should be used to inform the delivery of allied health services in RAC in the future.

Recommendation 8:

Conduct a consumer-centred evaluation of the allied health quality indicators.

The design of the allied health Quality Indicators should be evaluated by RAC consumers. The evaluation of the proposed allied health quality indicators should discern, through a trial and mixed method research, whether the proposed allied Quality Indicators are consistently understood by RAC consumers and whether the Quality Indicators provide RAC consumers with the information they require to choose a facility which meets their restorative and wellbeing care needs.

The proposed RAC Quality Indicators, lifestyle and leisure and allied health care quantity, must be transparent to consumers. This could be achieved by shaping the proposed Quality Indicators into two hierarchical indicators which are then consistently able to differentiate between workforce qualifications.

For example, the quantity of care provided by all university qualified professions outside medicine and nursing versus the quantity of care provided by all non-university qualified professionals outside medicine and nursing. This would provide clear tangible metrics, consistency with other Quality Indicators, and may future proof the Quality Indicators for future changes in the allied health workforce. However, allied health Quality Indicators must ultimately be guided by a thorough consumer-centred evaluation.

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Appendix 1. Long COVID and COVID-19 recovery advice provided by Australia's health departments.

	ACT (Australian Capital Territory Government, 2023)	NSW (New South Wales Health, 2023)	NT (Northern Territory Health, 2023)	QLD (Queensland Health, 2023)	SA (South Australia Health, 2023)	TAS (Primary Health Network Tasmania, 2023)	VIC (Department of Health, 2023b)	WA (Department of Health, 2023a)	Total
Audiology	✓	✓	✓	✓	✓	✓	✓	✓	8
Nutrition and dietetics	✓	✓	✓	✓	✓	✓	✓	✓	8
Occupational therapy	✓	✓	✓	✓	✓	✓	✓	✓	8
Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓	8
Physiotherapy	✓	✓	✓	✓	✓	✓	✓	✓	8
Podiatry	✓	✓	✓	✓	✓	✓	✓	✓	8
Psychology	✓	✓	✓	✓	✓	✓	✓	✓	8
Social work	✓	✓	✓	✓	✓	✓	✓	✓	8
Speech pathology	✓	✓	✓	✓	✓	✓	✓	✓	8
Exercise physiology	✓	✓		✓	✓	✓	✓	✓	7
Nuclear medicine technology	✓	✓	✓	✓	✓		✓	✓	7

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Orthoptics	✓	✓	✓	✓	✓		✓		6
Radiation therapy	✓	✓		✓	✓		✓	✓	6
Radiography	✓	✓	✓	✓	✓		✓		6
Sonography	✓		✓	✓	✓		✓	✓	6
Art therapy	✓	✓		✓	✓		✓		5
Music therapy	✓	✓		✓	✓		✓		5
Optometry				✓	✓	✓	✓		4
Oral Health and Dental Therapy	✓		✓		✓		✓		4
Biomedical engineering or science	✓						✓	✓	3
Chiropractors	✓					✓	✓		3
Genetic counselling	✓	✓			✓				3

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Medical laboratory science	✓		✓				✓		3
Perfusion	✓				✓			✓	3
Allied health assistants	✓						✓		2
Epidemiologists	✓				✓				2
Medical physics	✓							✓	2
Neurophysiology				✓				✓	2
Osteopathy	✓						✓		2
Respiratory scientists	✓							✓	2
Sleep science	✓							✓	2
Aboriginal and Torres Strait Islander health practitioners	✓								1

	ACT (Australian Capital Territory Government, 2023)	NSW (New South Wales Health, 2023)	NT (Northern Territory Health, 2023)	QLD (Queensland Health, 2023)	SA (South Australia Health, 2023)	TAS (Primary Health Network Tasmania, 2023)	VIC (Department of Health, 2023b)	WA (Department of Health, 2023a)	Total
Cardiac physiology					✓				1
Cardiac scientists	✓								1
Child life therapy		✓							1
Chinese medicine practitioners	✓								1
Clinical neurophysiology scientists	✓								1
Clinical physiology				✓					1
Clinical psychology								✓	1
Counsellors	✓								1
Dental assistants	✓								1
Dental prosthetists	✓								1

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Dental technicians	✓								1
Developmental educator					✓				1
Diabetes education						✓			1
Diversional therapy		✓							1
Environment health officers	✓								1
Environmental chemists	✓								1
Forensic chemists and toxicologists	✓								1

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Leisure therapy				✓					1
Medical librarianship								✓	1
Medical science								✓	1
Microbiologists	✓								1
Paramedics	✓								1
Pedorthists	✓								1
Physicists				✓					1
Radiation oncology medical physics							✓		1

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Rehabilitation engineering				✓					1
Sexual assault workers		✓							1
Welfare officers				✓					1

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AHHA acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA also pays our respect to their Elders past, present, and emerging as the custodians of knowledge